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ABSTRACT

Two models of family treatment are presented in which the child's nonverbal communication is as important as the adult's verbal communication, and the child is accorded equal respect with adult family members by the therapist. In the integrated conjoint family therapy model, children are present at family sessions, and the therapist responds to communications made by both adults and child(ren). Problems of conjoint therapy are discussed, including the disruptive behavior of children in therapy, language level problems, and the importance of hearing every family member. A concurrent model is also presented in which the therapist sees both the child individually and the family together in family sessions. Concurrent therapies are recommended when unresolved conflicts with an absent family member exist, as with the case of divorce, and when a child has internalized a sense of shame or badness which cannot be expressed to the parents. Problems in concurrent therapy are reviewed, focusing on issues of competition and integration of the child's individual therapy insights into family sessions. Case material is presented to illustrate techniques or integrating child and family therapy skills, as well as the difficulties and benefits of such an approach. (NRB)

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A CONCEPTUAL MODEL OF INTEGRATED CHILD AND FAMILY THERAPY

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A Conceptual Model of Integrated Child and Family Therapy

The case has been made (Levant & Haffey, 1980) that there is a strong need to integrate the theory, skills, and techniques of both child and family therapy when treating symptomatic children and their families. Individual child therapy has been shown to be less effective when practiced alone without the knowledge of family dynamics and the skills of family therapy (Ackerman, 1966; French, 1977; Haley, 1973; Smirnoff, 1971); likewise family therapy is less effective when practiced without the knowledge of child development and the skills of child therapy(Dare & Lindsey, 1979; Dowling & Jones, 1978; McDermott & Char, 1974).

In an integrated approach to family and child therapy, the child is seen both as a member of the family system and as an individual with his/her unique inner world and world view. The therapist needs to be able to communicate in the language of children as well as the language of adults. Two models of such an integrated approach will be presented and discussed, and the problems associated with these models will be examined.

An integrated model of conjoint family therapy is proposed in which each family member, regardless of age level, is accorded equal respect and importance by the therapist. In an integrated model of conjoint family therapy the children need to be present for family sessions and the therapist needs to be able to respond to children's communications using their language. This may involve engaging in play, reflecting feelings that the child displaces onto play figures, or simply speaking

more concretely. Being responsive to the child would entail speaking directly to the child rather than talking about the child to the parents. Therapy clearly becomes more complicated because in any given interaction, the therapist must choose between responding directly to the child, directly to the parents, or directing a response to all of them in reference to the interaction between them. The therapist needs to be able to converse in both adult and child language and be flexible and skilled enough to switch back and forth at appropriate times.

A major complaint about including children in family therapy is that children are disruptive, which is certainly true. Rarely is family therapy with young children orderly and harmonious; adults and children compete for the therapist's attention, using their two different styles of communication. The adults will try to talk while two children are fighting and a third tries to climb on the therapist's lap. Family life though is similarly disruptive, but with one important difference. In the family there is usually a set pattern for handling disruptions and establishing control. In the therapy room there isn't a set pattern. Children quickly begin to test the behavioral limits so that the issue of control becomes prominent very quickly and needs to be addressed by the therapist, whether in response to overly restrictive parents or to overly permissive parents. A more directive therapist would choose to establish control him/herself, setting the limits from the beginning on what is and is not permissible and taking responsibility for enforcing the limits. A more nondirective therapist might choose to explore the issue more reflectively. For example, in a family session with the family of a four year old, the child picked up a toy baby bottle in the room and began sucking on it. Her mother immediately berated her,

telling her not to do such a "baby" thing. The therapist then had to choose from one of several responses. She could assert control over what was permissible behavior in the play room thus contradicting the mother, she could respond to the child and explore both her feelings about not being allowed to suck the bottle and what she was going to do about it, or she could respond to the mother and explore either her feelings about the child being like a baby or her need to control that particular behavior. Ideally all these aspects of the interaction or of other interactions similar to this will be explored at some point. At each interaction, though, the therapist has to make choices about to whom she will respond and how.

Another problem of conjoint child and family therapy is that of the language level. Children communicate sometimes on a nonverbal level and frequently on a more concrete level than adults. If the therapist only speaks at the child's level, the adult family members may feel the therapist is being condescending toward them whereas if the therapist only speaks at the adult level, the children will not understand and will get bored. There needs to be a give and take between the two levels. The therapist might address the children at one level and the adults at another level of communication, explaining why s/he makes the shift, or the therapist might structure the interview so as to communicate for a certain amount of time as the child's level and for another amount of time at the adults' level.

A third concern in conjoint family and child work is to insure that every family member is heard. Especially when some family members communicate nonverbally it is easy to overlook their message. Again this is illustrated with the four year old and her family. The child's

parents were divorced, the father had very irregular visitation with the child, and one of the therapeutic goals was to encourage more consistent and regular visitation. In one of the meetings with the father and daughter, the father was discussing his conflictual relationship with the child's mother when Debra (the child) began to make noise and pound on a chair. She might have been reacting to her parents' embattled relationship but the therapist decided to respond to her and find out for herself. First she reflected that Debra seemed to be saying something, then her father asked what was wrong. Debra paused and then said to her father, "I don't like it when you do that." He asked what and she replied, "When you don't come when you say you will." The father explained that Debra was talking about the previous weekend when the father was late in picking her up. The therapist said that it seemed that Debra had some feelings about that and asked if there were anything he wanted to say to her about it. He then told Debra he was sorry, he didn't mean to be late, and that he wouldn't do it again.

Actually he probably would do it again but Debra learned that in that setting she could express herself directly to her father, her father learned that his being on time was important to Debra, and the therapist learned that a child's anxiety as expressed through noisemaking may be related as much to the content of the child's internal thoughts (Daddy was late last Saturday) as to the content of the adults' conversation (the relationship between the parents). The child's internal thoughts may be a reflection of the adults' conversation (When Daddy is late, Mommy says bad things about him. Why can't they get along?), but it is important that the child have an opportunity to express herself even when her thoughts may appear to be unrelated to the topic of

adult conversation.

In conjoint child and family therapy the therapist needs to be able to "switch gears" repeatedly throughout the session, focusing on the parents' verbal messages and the child's nonverbal messages. It cannot be assumed that the child's nonverbal behavior has a certain meaning, but rather the meaning must be explored with the child. A nonverbal message may reflect the family dynamics, it may reflect the child's fantasies or feelings, or it may reflect the interaction between fantasy and family relationships. Just as verbal communication is explored for its deeper meanings, so is nonverbal communication. The therapist must have skills in listening to, exploring, interpreting, and responding to both forms of communication.

Child and family therapy can be integrated in a concurrent model as well as in a conjoint model. In a concurrent model, the therapist would see both the child individually and the family together in family sessions. Just as it is appropriate to see the parents alone, perhaps to discuss marital issues, there are times when it is appropriate to see the child alone. The major question is when: When should the child be seen individually and when is conjoint therapy sufficient. The answer to that question is still somewhat unclear but there are at least two occasions when it seems necessary to see the child individually concurrent with family treatment. One such occasion is when a significant family member is absent and there are unresolved conflicts between remaining family members and the absent member. The absence of a significant family member seems to occur most frequently with divorced parents who remain in conflict with each other and continue to triangle the child into their conflicts. The absent parent frequently refuses to

be involved in therapy or may live too far away to be involved in therapy. The resulting situation, though, is one of a child being triangled into the parents' conflicted relationship with no way for the therapist to work with the parents directly to de-triangle the child. The child is left with numerous unexpressed feelings and conflicts concerning both parents and a lack of understanding about both the parents' relationship and the effect of that relationship on him/her. These seem appropriate issues on which to focus in individual therapy concurrent with family treatment.

Another appropriate occasion for the use of concurrent individual and family work is when the child has internalized a deep sense of shame or badness which s/he cannot or will not express to the parents. Perhaps the child cannot express a sense of shame because, although his/her behavior may indicate a very low self-esteem, the child is unaware of his/her underlying feelings. At other times, the child may be aware of guilty or shameful feelings but is unwilling to express them to the parents because of the parents' inability to either hear the child or be supportive of the child. It's not unheard of for a child to say to the parents that he feels like he is to blame for the family problems, only to have the parents agree with him, that he is to blame for all their problems. In such cases it seems necessary for the child to explore his/her feelings in individual treatment, in order to alleviate some of the guilt, and hopefully prevent a more serious conflict in the future.

There are certain problems which arise in the implementation of a concurrent model of child and family therapy, specifically around issues of competition and around integrating the child's insights from

individual work into the family sessions. Competition for the therapist's attention seems more intense when the child also sees the therapist individually. The child is accustomed to the therapist's undivided attention and doesn't particularly want to share that attention with other members of the family. Some children have real difficulty sharing the therapist's attention and will attempt a wide variety of acting-out behaviors to insure that the therapist's attention is focused on them. One child literally began to climb the walls during family sessions after the therapist began seeing him individually, and a lot of time was spent both in family and individual sessions discussing his anger at the therapist for not being "all his."

The problem of integrating into family therapy the child' insights from individual therapy must also be dealt with. The child may come to understand him/herself better in individual therapy and will want to (and need to) share those insights with the parents. There needs to be allowances for this in family therapy without family treatment becoming "show and tell time" for the child, with family treatment focusing only on the child to the exclusion of other family members and family relationships. One technique which can be utilized is a puppet show staged by the child and the therapist for the rest of the family. The puppet show would enact some family drama but would also reveal how the child felt about the drama, information that the child had not previously shared with the parents. An eleven year old girl and her therapist recently staged such a puppet show for the family, revealing that after the girl's angry outbursts at her mother, she would retreat to her room and cry, feeling very guilty for what she had said. The puppet show ended with the puppet daughter apologizing to the mother and

the mother accepting the apology, something which had not yet happened in real life. The puppet show stimulated a discussion and a better understanding not only about the girl's feelings but about the mother's feelings as well.

What is being conceptualized is a model of family therapy which truly integrates the theory and techniques of both family therapy and child therapy. As in any model, there are difficulties as well as benefits in its implementation. Hopefully the benefits will prove greater than the problems when the model is offered as a form of treatment for the child-focused family and its members.

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